



South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: (605) 362-2768 ♦ www.nursing.sd.gov

Reinstatement of Lapsed APRN License

Please follow instructions carefully to avoid delays in processing of your CNM, CNP, CRNA, or CNS license. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees your application will be considered for reinstatement. You will be notified in writing if additional information is required.

South Dakota nursing licenses expire on a licensee's birth date, every other year. If not renewed by the expiration date, the license(s) lapses and must be reinstated *prior* to resuming practice.

Provisions in law relating to lapsed licenses and practicing without a valid license:

SDCL 36-9-47 - Reinstatement of lapsed license.

SDCL 36-9-49 (9) - Grounds for denial, revocation or suspension of license, certification or application.

SDCL 36-9-68 (5) - Prohibited Acts – Misdemeanor.

SDCL 36-9-71 - Unlicensed practice of nursing as a public nuisance.

SDCL 36-9A-24 Reinstatement of Lapsed License.

SDCL 36-9A-35 - Prohibited Acts – Misdemeanor.

ARSD 20:48:03:12 - Lapse and reinstatement License.

ARSD 20:62:02:07 - Reinstatement of Lapsed Licenses.

To reinstate your APRN license you must hold an active South Dakota RN license or an active multi-state compact RN license.

- If your South Dakota RN license has lapsed you must reinstate your South Dakota RN license.

The South Dakota Board of Nursing is a part of the ***Enhanced Nurse Licensure Compact*** (eNLC) (SDCL 36-9-98). There are new features in the provisions of the legislation of the eNLC. Licensing standards are aligned in eNLC states so all applicants for a multistate nursing license are required to meet the same standards. One of the standards is a criminal background check at the time of initial licensure.

If you were originally licensed **prior** to July 2006 you did not have a criminal background check completed in South Dakota. In order to be eligible for a multistate license you must complete a criminal background check and declare South Dakota as your primary state of residence. Please request a criminal background check packet from the SD Board of Nursing by calling 605-362-2760 or emailing Abbey.Bruner@state.sd.us.

- If your multi-state compact license has lapsed, contact that state's Board of Nursing to complete requirements for reinstatement.

To REINSTATE your APRN license, *submit the following* to the South Dakota Board of Nursing office:

- Completed Application to Reinstate Lapsed APRN (and RN) License indicating license(s) to be reinstated.
- Completed Employment Verification Form
- Fee payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A \$20 fee will be charged for any insufficient check written.

Fees required to reinstate South Dakota nursing licenses:	
\$115	RN renewal fee
\$50	RN reinstatement fee
\$95	APRN renewal fee
\$50	APRN reinstatement fee
= \$310	Total to reinstate both a SD RN license and a SD APRN license
= \$145	Total to reinstate only a SD APRN license



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Application to Reinstate Lapsed APRN (and RN) License

I request to REINSTATE each license checked:

- | | |
|--|---|
| <input type="checkbox"/> SD RN License Number: _____ | <input type="checkbox"/> CRNA License Number: _____ |
| <input type="checkbox"/> CNM License Number: _____ | <input type="checkbox"/> CNS License Number: _____ |
| <input type="checkbox"/> CNP License Number: _____ | |

Why did your nursing license(s) lapse? _____

Have you worked in South Dakota on this lapsed license? _____ YES _____ NO

If YES, where and when? _____

Name(Last): _____ (First): _____ (Middle): _____

Name(Other): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone(Home): _____ (Work): _____ (Cell): _____

Date of Birth: _____ / _____ / _____ Email Address: _____
month day year

Declaration of Primary State of Residence

I declare _____ to be my primary state of residence. Primary state of residence is where you hold a driver's license, pay taxes and/or vote. This state is referred to as my "home state" under the Nurse Licensure Compact and means that it is my "declared fixed permanent and principal home for legal purposes".

The following can be used to document residency pursuant to the Compact laws and rules.

1. Driver's license with a home address.
2. Voter registration card displaying a home address.
3. Federal income tax return declaring the primary state of residence.
4. Military Form No. 2058 – state of legal residence certificate.
5. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

For Office Use Only:



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Military / Federal Employees

A federal government/military nurse practicing exclusively in federal or military systems, need only have one license from any state or territory per U.S. federal government/military policy. A federal or military nurse who also practices in a civilian health systems is bound by the Compact law and rules.

A federal/military nurse who has proof of residency in a Compact party state may be issued a Compact license with a multi-state practice privilege. A federal/military nurse who does not have proof of residency in a Compact party state may be issued a single-state license regardless of where the nurse is residing. A military/federal nurse may not hold a multi-state license from more than one Compact state at a time.

Are you employed by the military or practicing in a Federal institution?

- ☐ **Yes**
- ☐ **No**

CNM and CNP Practice Authority Status

Collaborative agreements are not required for CNMs and CNPs that have met a minimum of 1,040 hours of licensed practice in the role of a CNM or CNP.

- ☐ Have met the minimum number of hours and am not required to have a collaborative agreement on file.
- ☐ I have not met the minimum number of required hours; I have a collaborative agreement on file with the SD Board of Nursing.
- ☐ I have not met the required hours; I plan to submit a collaborative agreement. I understand I may not practice in role of CNP or CNM until this agreement is on file and approved by Board.

Certification Information

Primary source verification of *current* certification from a Board-approved certification body specific to your area of practice is *required* to be on file with the Board office prior to your APRN license being reinstated. If you are unsure if current certification is on file contact the Board office. Photocopies of certification documents are not accepted.

- ☐ My primary source verification of current certification is already on file with the BON office.
- ☐ My primary source verification of current certification is NOT on file with the BON: I will request my certifying organization send verification directly to the SD BON office.
- ☐ CRNAs primary source re-certification verification will be monitored via NCSBN and NBCRNA's websites, no need to submit.
- ☐ I am exempt from the certification requirement. I was originally licensed as a CNP/CNM in South Dakota before June 26, 1996 or as a CNS before July 1, 1996 and have never submitted certification evidence to the Board for licensure purposes.



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Compliance Information

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

1.	Have you been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations, that have not previously been reported to the board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Have you had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Are you currently enrolled in an Alternative to Discipline Program? (ie SD HPAP.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you experienced a physical, emotional, or mental condition that has endangered or posed a direct threat to the health or safety of persons entrusted to your care or your ability to safely practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Do you currently owe child support arrearages in the amount of \$1000 or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Employment and Education Information:

What type of nursing degree / credential qualified you for your first U.S. nursing license?

- | | |
|---|---|
| <input type="checkbox"/> Vocational / Practical Certificate Nursing | <input type="checkbox"/> Baccalaureate Degree – Nursing |
| <input type="checkbox"/> Diploma – Nursing | <input type="checkbox"/> Master's Degree – Nursing |
| <input type="checkbox"/> Associate Degree – Nursing | <input type="checkbox"/> Doctoral Degree – Nursing |

What is your highest level of education?

- | | | |
|---|---|---|
| <input type="checkbox"/> Vocational/Practical Nursing Certificate | <input type="checkbox"/> Baccalaureate Degree – Nursing | <input type="checkbox"/> Doctoral Degree – Nursing Practice (DNP) |
| <input type="checkbox"/> Diploma – Nursing | <input type="checkbox"/> Baccalaureate Degree – Non-Nursing | <input type="checkbox"/> Doctoral Degree – Nursing Other |
| <input type="checkbox"/> Associate Degree – Nursing | <input type="checkbox"/> Master's Degree – Nursing | <input type="checkbox"/> Doctoral Degree – Non-Nursing |
| <input type="checkbox"/> Associate Degree – Non-Nursing | <input type="checkbox"/> Master's Degree – Non-Nursing | |
| | <input type="checkbox"/> Doctoral Degree – Nursing (PhD) | |

Year of initial U.S. Licensure: _____

Country of entry-level education: _____



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What is your employment status?

- ☐ **Actively employed in nursing or in a position that requires a nurse license (select one)**
 - ☐ Full-time
 - ☐ Part-time
 - ☐ Per diem
- ☐ **Actively employed in a field other than nursing (select one)**
 - ☐ Full-time
 - ☐ Part-time
 - ☐ Per diem
- ☐ **Working in nursing only as a volunteer**
- ☐ **Unemployed (select one)**
 - ☐ Seeking work as a nurse
 - ☐ Not seeking work as a nurse
- ☐ **Retired**

In how many positions are you currently employed as a nurse?

- ☐ 1
- ☐ 2
- ☐ 3 or more

How many hours do you work during a typical week in all your nursing positions?

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> <10 hours | <input type="checkbox"/> 41-50 hours |
| <input type="checkbox"/> 11-20 hours | <input type="checkbox"/> 51-60 hours |
| <input type="checkbox"/> 21-30 hours | <input type="checkbox"/> >60 hours |
| <input type="checkbox"/> 31-40 hours | |

Indicate the zip code, city, state and county of your primary employer.

Zip Code: _____
City: _____
State: _____
County: _____

Identify the type of setting that most closely corresponds to your nursing practice position.

- | | | |
|--|--|---|
| <input type="checkbox"/> Academic Setting | <input type="checkbox"/> Hospital | <input type="checkbox"/> Policy / Planning Regulatory / |
| <input type="checkbox"/> Ambulatory Care Setting | <input type="checkbox"/> Insurance Claims / Benefits | Licensing Agency |
| <input type="checkbox"/> Community Health | <input type="checkbox"/> Nursing Home / Extended | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Care / Assisted Living Facility | <input type="checkbox"/> School Health Services |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Other |

Identify the position title that most closely corresponds to your nursing practice position.

- | | | |
|---|---|---|
| <input type="checkbox"/> Advanced Practice RN | <input type="checkbox"/> Nurse Faculty | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Nurse Manager | <input type="checkbox"/> Other – Health Related |
| <input type="checkbox"/> Nurse Executive | <input type="checkbox"/> Nurse Researcher | <input type="checkbox"/> Other – Non Health Related |



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Identify the employment specialty that most closely corresponds to your nursing practice position.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acute Care/ Critical Care | <input type="checkbox"/> Medical / Surgical | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Adult Health / Family Health | <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Oncology | <input type="checkbox"/> School Health |
| <input type="checkbox"/> Community | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Geriatric / Gerontology | <input type="checkbox"/> Pediatrics / Neonatal | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Psychiatric / Mental Health / | <input type="checkbox"/> Other |
| <input type="checkbox"/> Maternal-Child Health | Substance Abuse | |

What percent of your current position involves direct patient care?

- | | | |
|------------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> 0% | <input type="checkbox"/> 50% | <input type="checkbox"/> 100% |
| <input type="checkbox"/> 25% | <input type="checkbox"/> 75% | |

If unemployed, please indicate the reasons.

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty in finding a nursing position | <input type="checkbox"/> Inadequate Salary | <input type="checkbox"/> Taking care of home and family |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> School | <input type="checkbox"/> Other |

Formal Education

- | |
|---|
| <input type="checkbox"/> I am not taking courses toward an advanced degree in nursing |
| <input type="checkbox"/> I am currently taking courses toward an advanced degree in nursing |

Do you intend to leave / retire from nursing practice in the next 5 years?

- | |
|------------------------------|
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> No |

Other states in which you have ever held a license:

Active License: _____
Inactive License: _____

List all states where **currently practicing** nursing, whether physically or electronically:

Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____



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Verification of Employment

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. Return completed form(s) via fax, email or mail to the South Dakota Board of Nursing.

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

Please Print

Name (First): _____ (Middle): _____ (Last): _____

☐ I have been employed / volunteered as a nurse (LPN, RN, CRNA, CNM, CNP or CNS).

☐ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

Signature of Applicant

Date

**This Section to be Completed by Employer
(Provide Employment Hours Within the Last 6 Years)
Note: This section cannot be Signed by the Applicant**

The above-named individual is/was employed/volunteered as a nurse

From _____
Month/Date/Year

To _____
Month/Date/Year

Total hours worked in this period: _____

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

Signature of Agency Representative/Title

Date

Who can verify/confirm number of hours employed/volunteered

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____